

Applicant 04-\_\_\_\_\_

## PARTNERS IN POLICYMAKING

### Application for Participation

*Funded by the Indiana Governor's Council for Persons with Disabilities*

**(Application Deadline is the first Friday of June.**

**Please be as thorough as possible.)**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ COUNTY: \_\_\_\_\_

CURRENT EMPLOYER: \_\_\_\_\_

POSITION: \_\_\_\_\_

DAY TELEPHONE: (\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_\_

EVENING TELEPHONE: (\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_\_

E-MAIL: \_\_\_\_\_

Who referred you to PIP? Please give name/agency. \_\_\_\_\_

#### DEMOGRAPHIC INFORMATION

(Confidential: For statistical purposes only)

**Applicant:** ☐ Female ☐ Male  
☐ Person with a Disability ☐ Primary Caregiver (Parent, GrParent)

**Age:** ☐ 18-29 ☐ 30-39 ☐ 40-49 ☐ 50-59 ☐ 60-69 ☐ 70+

**Household Income:** ☐ \$0-\$15,000 ☐ \$15,001-\$25,000 ☐ \$25,001-\$35,000  
☐ \$35,001-\$50,000 ☐ \$50,001+

**Region:** ☐ North-East ☐ North-Central ☐ North-West  
☐ Central-East ☐ Central ☐ Central-West  
☐ South-East ☐ South-West

**Race or National Origin:** ☐ African-American ☐ Asian ☐ Caucasian  
☐ Hispanic ☐ Native American ☐ Other \_\_\_\_\_

**Marital Status:** ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Applicant # 04-\_\_\_\_\_

1. Are you a person with a disability? ☐ Yes ☐ No

2. Are you a parent of a son or daughter with a disability? ☐ Yes ☐ No

3. If you are a parent of a child/children with a disability, please indicate the following:

Child 1: Age:\_\_\_\_\_ Gender:\_\_\_\_\_ Disability:\_\_\_\_\_

Child 2: Age:\_\_\_\_\_ Gender:\_\_\_\_\_ Disability:\_\_\_\_\_

Child 3: Age:\_\_\_\_\_ Gender:\_\_\_\_\_ Disability:\_\_\_\_\_

Other Children in household:

Age:\_\_\_\_\_ Gender:\_\_\_\_\_

Age:\_\_\_\_\_ Gender:\_\_\_\_\_

Age:\_\_\_\_\_ Gender:\_\_\_\_\_

4. Please describe your disability (and/or your family member's) and how it affects self-care, learning, receptive and expressive language, mobility, capacity for independent living; economic self-sufficiency.

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5. What services (education, respite care, vocational training, case management, etc.) do you and your family member receive?

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6. If applicable, describe you or your child's school placement.

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7. Why are you interested in participating in Partners in Policymaking? Is there a specific issue, problem, or area of concern that encouraged you to apply?

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8. Please tell us how you learned about Partners in Policymaking?

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9. Have you applied for Partners in Policymaking before? \_\_\_\_\_ How many times? \_\_\_\_\_

10. Please tell us a little about yourself and your family? (You may use back side.)

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11. Do you currently belong to any advocacy or civic organizations or support groups? If so, please list them along with any offices you may hold. (Note: Membership in other organizations is not a requirement for your participation in this project.)

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12. What skills, knowledge and abilities do you hope to gain if you are accepted into the Partners in Policymaking?

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13. How will you use the skills and information you acquire for yourself/family, for others and community?

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14. Will you make a time commitment of two days (Friday and Saturday) once per month for 8 months?

**Attendance at all sessions is mandatory!**      \_\_\_\_\_ Yes      \_\_\_\_\_ No

15. If you are employed, have you talked with your employer and arranged your work schedule?

\_\_\_\_\_ Yes      \_\_\_\_\_ No

16. Sessions will be held in the Indianapolis area? Is there any reason why you may not be able to travel to the area?

\_\_\_\_\_ Yes      \_\_\_\_\_ No

17. Can you attend the Indiana Governor's Council for People with Disabilities Conference, which will be scheduled for late Fall.?

\_\_\_\_\_ Yes      \_\_\_\_\_ No

18. Do you agree to complete monthly homework assignments?

\_\_\_\_\_ Yes      \_\_\_\_\_ No

19. Are there any accommodations that you need to participate in this program?

\_\_\_\_\_ Yes      \_\_\_\_\_ No

If yes, please check the accommodations that you need.

\_\_\_\_\_ Interpreters

\_\_\_\_\_ Respite Care for child with disability

\_\_\_\_\_ Child care for siblings

\_\_\_\_\_ Personal Care Attendant

\_\_\_\_\_ Wheelchair Accessible Room: \_\_\_\_\_

\_\_\_\_\_ Alternative Formats for learning materials- please describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Other (describe):

**20. PLEASE LIST TWO REFERENCES** (with current addresses and phone numbers)  
**NO FAMILY MEMBERS:**

1. Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Day Time Phone: \_\_\_\_\_

Email: \_\_\_\_\_

2. Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Day Time Phone: \_\_\_\_\_

Email: \_\_\_\_\_

21. Do you have more information you want to share? (You may attach sheets or use the back of the application.)

**If you have questions or need additional information contact:**

**Partners in Policymaking (PIP)**  
**1915 West Eighteenth Street, Suite C**  
**Indianapolis, IN 46202-1016**  
**(317) 632-3578 Voice**  
**(317) 632-2999 Fax**  
**(800) 821-6708 Toll-Free**  
**[pip@ucpaindy.org](mailto:pip@ucpaindy.org) (e-mail)**

This information is posted on the Governor's Planning Council for People with Disabilities  
web-site at

**<http://www.in.gov/gpcpd>**

\*This application can be made available in accessible formats upon request.